

Assessing
the
Health
of
Older Adults
in
Kent County

Report to the Community
2000



Assessing the Health of Older Adults in Kent County: Report to the Community, 2000

Copies of this report are available on the Kent County Health Department web site at www.co.kent.mi.us/health/publications.htm

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Introduction

Assessing the Health of Kent County's Older Adults

Decreasing birth rates and increases in life span have resulted in a change in the number of adults aged 65 and over in Kent County. Between 1980 and 1990, there was a 19% increase in the number of adults older than 65 and a 24% increase in those over 75 years old in Kent County, a trend that is expected to continue. While Medicare assures the availability of at least minimal health care for adults over 65, there are significant disparities in both the health of and health care for older adults, based primarily on socioeconomic status, specifically the ability to pay "out of pocket" for health care needs.

This report includes information about the morbidity and mortality of the chronic diseases responsible for 66% of the deaths to Kent County residents over age 65: heart disease, cancer, and cerebrovascular disease (stroke). Where possible, race/ethnicity data have been included to aid in planning for the health care needs of all population groups within the county. Unfortunately, due to a number of factors that affect the validity and reliability of health-related data, little information is available for Hispanics, Asian/Pacific Islanders, and American Indians in Kent County. Consequently, in many cases, it is difficult to associate disparities in health status with the quality of, or access to, available health care.

Identifying meaningful indicators of disparity in health status of older adults will require input from professionals who work to assure their health, as well older adults themselves. For example, because individual behavior is strongly associated with each of the leading causes of death or hospitalization, understanding how the older population (and the population in general) perceives and works to improve their individual risks is critical. Assessing these factors will require a renewed commitment from health systems to collect (and help report on) more detailed demographic and behavioral risk factor information with clinical encounters.

Finally, monitoring access to necessary services and treatments aimed at reducing the sequelae (after-effects) of chronic disease (e.g., blindness as a result of diabetes) should be a priority for public health, and the health care community generally. However, at this time, and for lack of objective data, much of the information that suggests that there are still significant local disparities in access to services (e.g., physical therapy) or treatments (e.g., prescription drugs) is largely anecdotal. Improving data collection within health systems – hospitals, HMOs, community clinics – as well as continued community-based assessment through initiatives such as Healthy Kent and Delta Strategy will be critical to assuring optimal access and health outcomes for our elderly population.

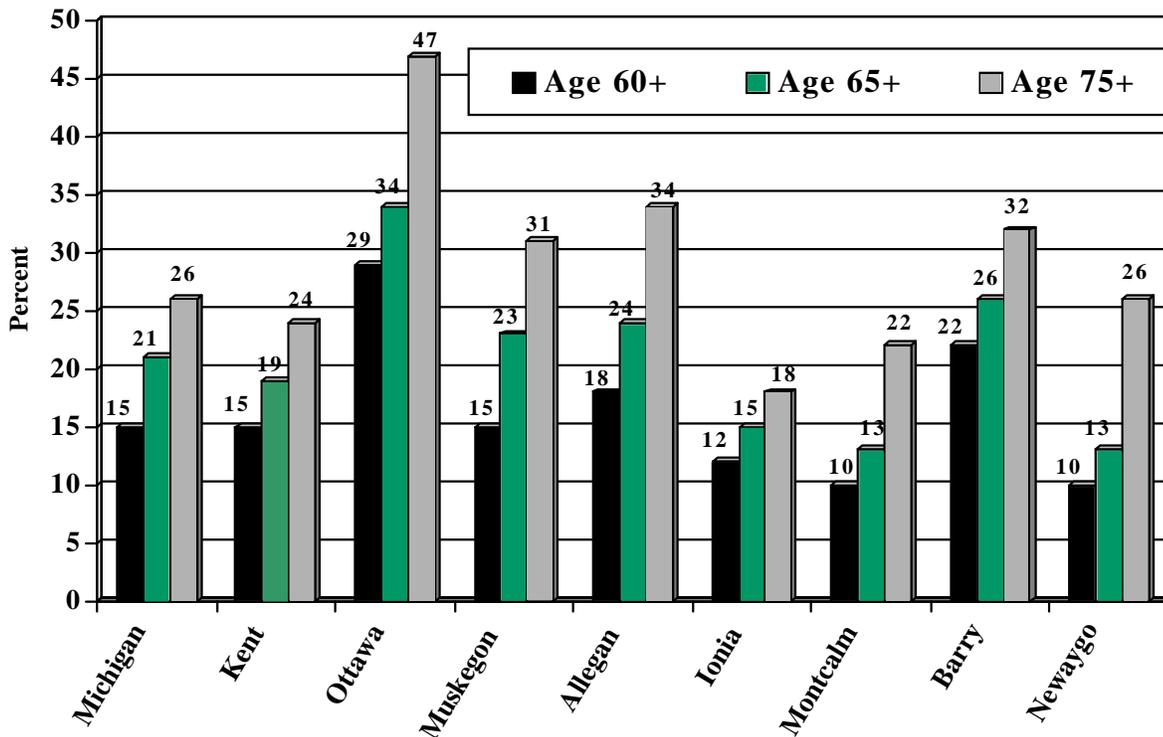
Demographics

Increase in Population of Adults Over 60 in West Central Michigan

Between 1980 and 1990, every county in West Central Michigan saw their older adult population grow – both in numbers, and as a percentage of the total population. Growth in Kent County was similar to that in Michigan overall with a 19% increase in adults age 65 and over, and a 24% increase in adults age 75 and over. Even larger increases were observed in Muskegon, Allegan, and Barry Counties. Of all the counties in West Central Michigan, Ottawa County experienced the greatest growth in older adults: a 34% increase in adults age 65 and over, and a 47% increase in adults age 75 and over.¹

By 1998 there were an estimated 61,801 persons age 65 and older in Kent County, representing 11.3% of the population.² This trend is expected to continue as the “baby boom” generation begins to enter their retirement years in approximately 2010. These changes in the age distribution of the population – the increasing percentage and number of older adults – will necessitate increased Medicare spending simply to maintain services at existing levels. Unfortunately, recent efforts to control both Medicare and Medicaid spending (i.e., transitioning these programs to capitated managed care plans) have taken a significant toll on health care systems, and their ability to provide care within communities. Every effort should be made to assess the effects of cost cutting on the health and medical outcomes of the vulnerable populations who rely on these safety net programs.

Percentage Increase in Population by Age Group, West Central Michigan, 1980-1990



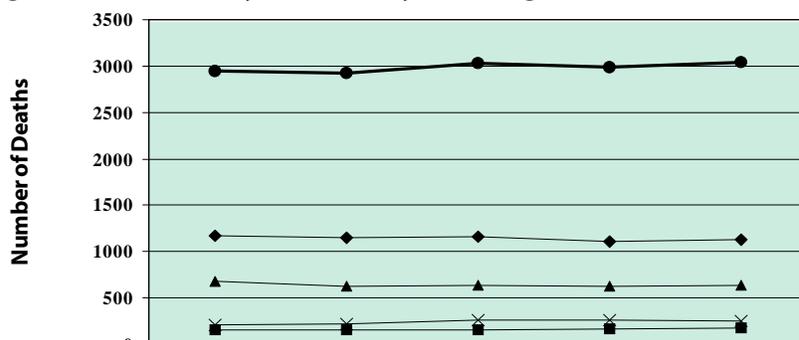
Mortality

Leading Causes of Death

There were 3041 deaths of adults older than 65 years in 1998 (Age Specific Rate = 49.2/1,000). The leading cause of death remains heart disease, accounting for 37% of all deaths to persons older than 65. Cancer, cerebrovascular disease, complications due to pneumonia or influenza, and chronic obstructive pulmonary diseases (COPD, e.g., emphysema and asthma) complete the list of the top five causes of death in Kent County. Together these diseases account for over three-quarters (76%) of all deaths to adults aged 65 years and older.

Diabetes, all accidents, and nephritis (kidney disease) complete the list of leading causes of death for Kent County residents age 65 and over. There is, however, a strong interrelationship between the leading causes of death as multiple (bodily) systems are generally involved at the time of death. Diabetes or kidney failure, for example, may be contributing factors for the development of heart disease or stroke but not the primary cause of death. Although physicians can code primary as well as several secondary causes of death on a death certificate, mortality data generally represents only the primary cause of death.

Leading Causes of Mortality, Kent County Adults Age 65 and Over

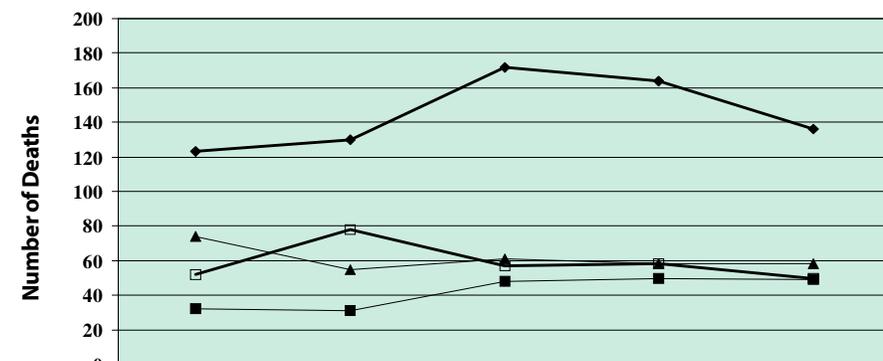


	1994	1995	1996	1997	1998
Total Deaths >= 65	2945	2924	3027	2992	3041
Heart Disease	1172	1148	1161	1112	1133
Cancer	675	632	642	625	637
Cerebrovascular Diseases	211	219	259	258	246
Pneumonia/Flu	156	159	159	167	174

Kent County rates for heart disease, pneumonia/influenza, and kidney disease remain somewhat higher than national rates, however, only deaths due to pneumonia/influenza increased in Kent County from 1996 through 1998.

All of the leading causes of death have strong behavioral risk components. Tobacco use, obesity, and exercise/activity (or inactivity) level are associated with most of the leading causes of death. Decreasing the use of tobacco and levels of obesity, and increasing opportunities for physical activity for Kent County residents should be a priority of both the health care systems and public health.

Significant Causes of Mortality, Kent County Adults Age 65 and Over



	1994	1995	1996	1997	1998
COPD	123	130	172	164	136
Diabetes	74	55	61	58	58
Accidents	52	78	57	58	50
Nephritis	32	31	48	50	49

The table on the next page contains the most recent comparative data (rates per 100,000 population) for the leading causes of death. National data were taken from a CDC Surveillance Summary of selected health indicators for older adults.³

Mortality

Leading Causes of Death per 100,000 population³

Cause of Death	U.S. 1996	Kent 1996	Kent 1998
Heart Disease	1808	1908	1833
Malignant Neoplasms	1131	1055	1031
Cerebrovascular Disease	415	426	398
Pneumonia/Influenza	221	261	282
COPD	270	283	220
Diabetes Mellitus	137	100	94
Accident	91	94	81
Kidney Disease	62	79	79

Accidents, Suicide and Homicide

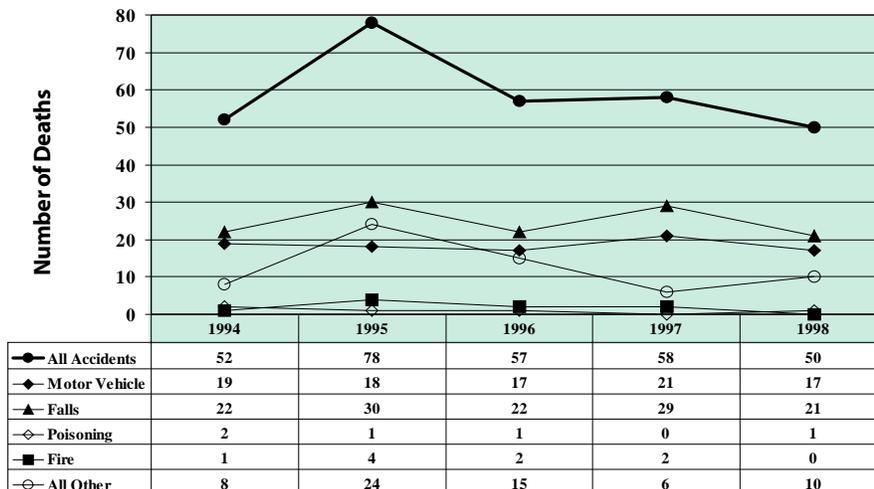
Falls account for the largest percentage (42%) of accidental deaths for adults older than 65 in Kent County. Thirty-four percent of accidental deaths (17) for this age group in 1998 were due to motor vehicle accidents.

While the homicide rate among the older adults remains relatively low, the Kent County Violence Prevention Coalition, part of Healthy Kent 2010, continues to track other indicators related to elder violence. Physical assaults and other forms of elder abuse (maltreatment) may be more representative indicators of the quality of life for Kent County's senior population.

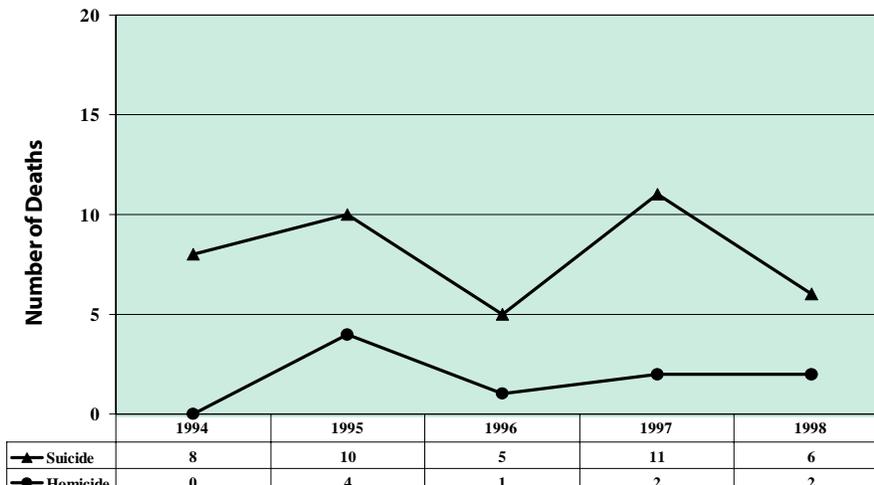
The suicide rate among adults over 65 was 1.2/10,000 (1996-98, 3 year average), an average of 7.3 (standard deviation \pm 3.21) suicides per year. Suicide is one indicator of the mental health status of a population. Depression and other forms of mental illness often go unreported and untreated in senior populations as access to mental health services may be limited. The individual mental health status of older adults may also be given less consideration than physical health concerns.

Risks for deaths due to falls, and to some extent motor vehicle accidents and suicide, could include factors such as the prevalence of osteoporosis, pre-senile dementia (e.g., Alzheimer's disease), neurological diseases (e.g. Parkinson's

Accidental Deaths Among Kent County Adults 65 and Over



Suicide and Homicide Among Kent County Adults 65 and Over



Mortality

disease), mental depression, and poor vision, all of which are difficult to estimate at a local level. The extent to which each of these factors, and all of these factors, impacts mortality rates of Kent County's older adults is impossible to establish with current health data. However, determining how each of these factors is managed by the health care system to improve or maintain the quality of life for Kent County's older adults is perhaps a more important consideration.

Racial Disparities in Health Outcomes among Kent County's Older Adults

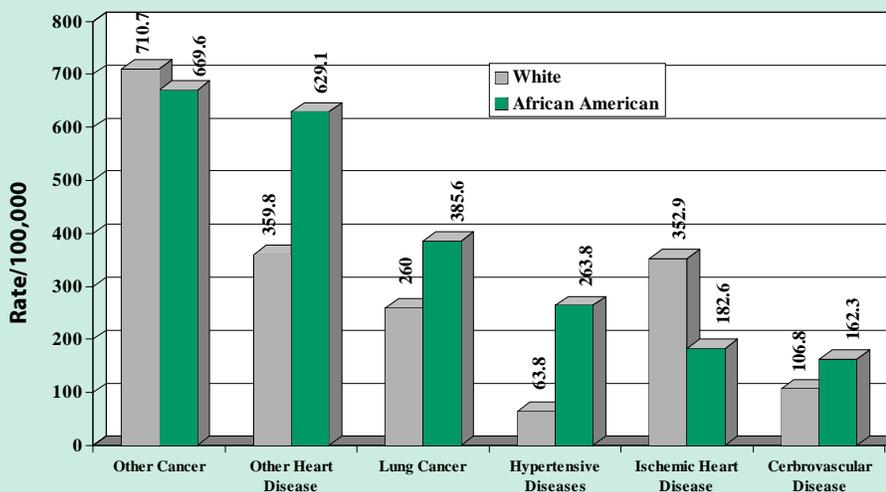
One useful tool for assessing the health status of a population is comparing data about that population to data about another population. Unfortunately, in Kent County, there are several populations for which existing local data is unreliable: Asian/Pacific Islanders, American Indians, and persons of Hispanic descent. Although the Asian/Pacific Islander population experienced the largest growth of any population in Kent County since 1990, their still-small numbers, and particularly the small numbers of occurrences for the leading causes of death, make comparisons among populations unreliable. The American Indian population of Kent County experienced essentially no growth over the same period and, therefore, comparison to other populations suffers the same unreliability as the Asian/Pacific Islander population.

Among the population of persons of Hispanic descent, inconsistent reporting of ancestry or

ethnic classifications often compromises data reliability. Improving our ability to report on racial or ethnic inequities in health status will require more standardized methods for the collection of information at the primary care level. While data from clinical encounters or diagnostic procedures (given by local or neighborhood clinics) may provide the best data related to the health status of the Hispanic population, valid comparisons among populations rely on the ability to accurately count the entire population so representative rates can be developed. Hopefully, the year 2000 census will provide more accurate estimates of the Hispanic population in Kent County.

When comparing rates between the two populations large enough to be statistically reliable in Kent County — African Americans and Whites — small annual numbers of occurrences for some causes of death make yearly

Leading Causes of Death, by Race, Kent County Adults 65-74



Mortality

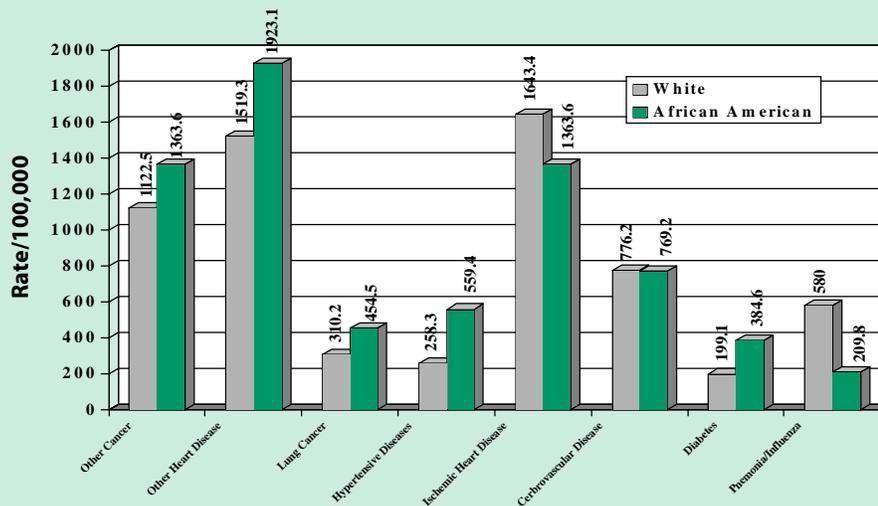
comparisons unreliable. For this reason, mortality data in this study are reported in three-year average age specific rates (1996-1998) for each of the leading causes of death (age groups: 64 to 75 years old, and age greater than 75 years old).

Deaths due to heart disease can be separated into several categories including ischemic heart disease (atherosclerotic heart disease), hypertensive diseases (high blood pressure, which can affect multiple systems), and other heart diseases (congestive heart failure, valvular disorders). For persons age 64 to 75, “other heart diseases” accounted for the largest percentage of deaths (due to heart disease) for both African Americans and Whites in Kent County (rates = 6.3/1,000 and 3.6/1,000 respectively). In this age group, African Americans have higher rates of death for each of the leading causes of death with the exception of ischemic heart disease and “other cancer” (all

cancers other than cancers of the lung). For persons 75 years and older in Kent County, the trend is similar: “other heart disease” accounts for the largest percentage of African Americans deaths, and ischemic heart disease is responsible for the largest share of White deaths. Here again, African Americans in Kent County have higher rates of death for each of the leading causes of death except ischemic heart disease, pneumonia/influenza, and cerebrovascular disease.

Determining the extent of racial disparities in health care using mortality data alone is difficult however. While there are significant differences in the rates for most of the leading causes of death, data on socioeconomic status and other confounding variables – if such data were available — would allow our community to develop a more complete picture of health disparities between population groups in Kent County.

Leading Causes of Death, by Race, Kent County Adults Age 75 and Over



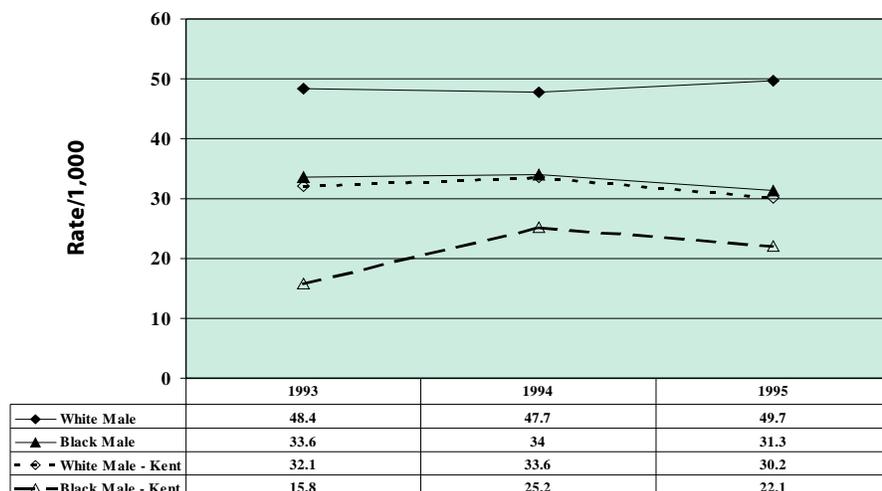
Morbidity and Chronic Disease

Leading Causes of Hospitalization

Hospital discharge data is another commonly used measure to estimate the prevalence of disease in a population (these data represent diagnosis at the time of discharge). The Division of Vital Records and Health Statistics (DVRHS), Michigan Department of Community Health, re-aggregates data received by the Michigan Hospital Association to produce county-specific hospitalization rates by age and gender. (The Division of Vital Records has not released race-specific data after 1996 however, limiting the data available to make comparisons of local and state hospitalization rates.)

Data are provided here through 1996 for discharges due to ischemic heart disease, "other heart disease," and cerebrovascular disease (stroke), all of which support suggestions that there is not equal access to preventive and primary care for Kent County African Americans. There are limitations with these data, as the racial/ethnic information is self-reported and missing in 18.7% of discharge records.² However, in general, differences in rates for the leading causes of hospitalization between African Americans and Whites mirror national trends, with higher rates for the African American population.

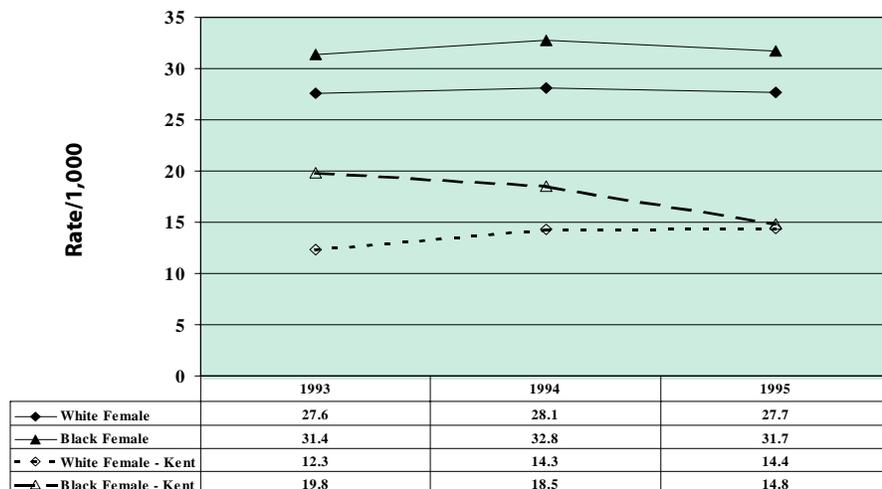
Ischemic Heart Disease, by Race, Males Age 65-74



Ischemic Heart Disease and Cerebrovascular Disease

Retrospective studies of national death data show increases in atherosclerosis and diabetes in the African American population (2-3 times higher than white rates). Higher prevalence of both hypertension and tobacco use likely play a key role in these differences.⁴ Understanding differences between populations is dependent upon the quality of information collected to document the morbidity of the disease process. Unfortunately, here again, there is a lack of valid longitudinal data that are necessary to make accurate associations between age- and race-specific behavioral and physiologic risk factors for chronic disease.

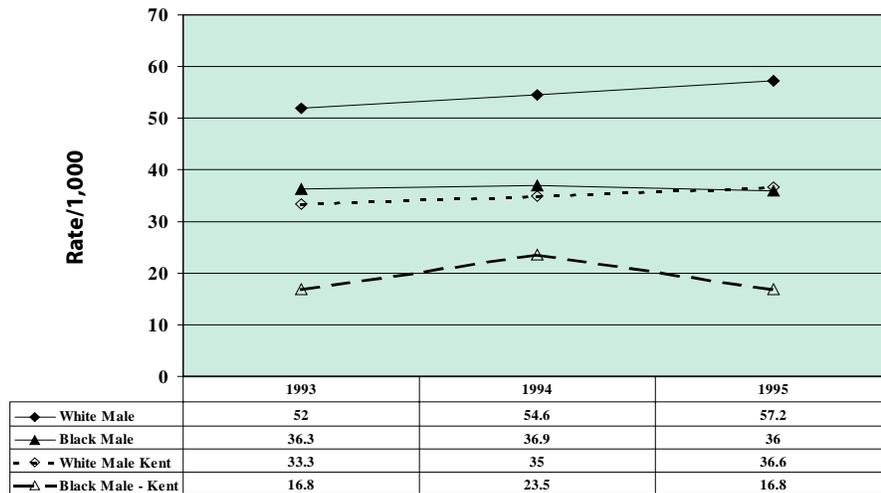
Ischemic Heart Disease, by Race, Females Age 65-74



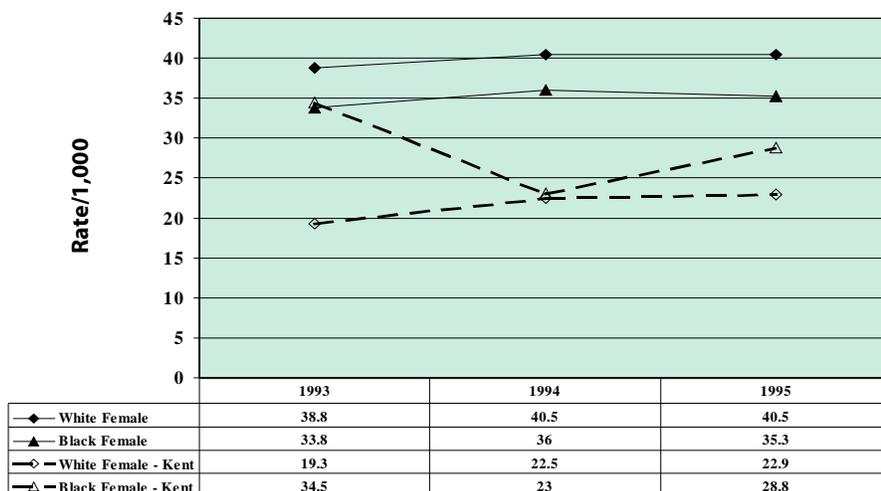
One of the principle age-related physiologic risks for heart disease and strokes is atherosclerotic disease (the deposit of "fatty plaques" in the walls of blood vessels). Recent cross-sectional studies suggest that Low Density Lipoprotein (LDL),

Morbidity and Chronic Disease

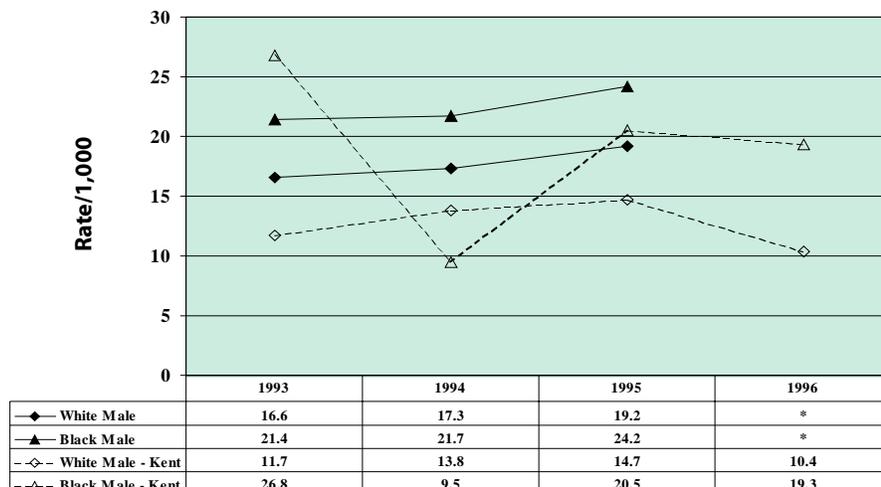
Ischemic Heart Disease, by Race, Males Age 75 and Over



Ischemic Heart Disease, by Race, Females Age 75 and Over



Cerebrovascular Disease, by Race, Males Age 65-74



and in particular Lipoprotein (a), is a strong predictor of heart disease, strokes, and peripheral vascular disease. Lipoprotein (a) levels were twice as high for African Americans than for Whites in the Atherosclerotic Risk in Communities Study.⁴

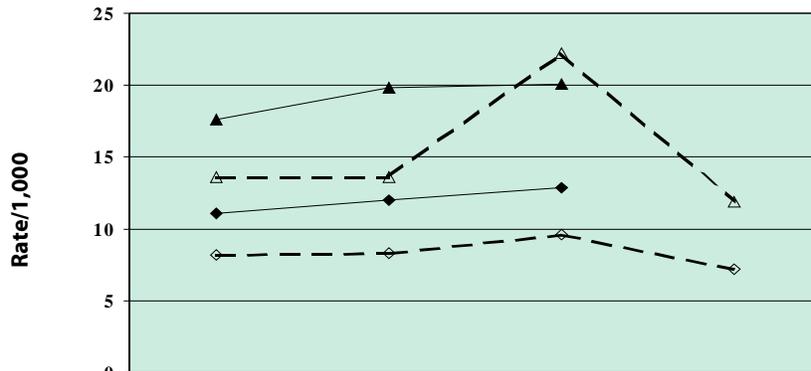
Diabetes has a strong association with each of the leading causes of death, as well as with the leading causes of hospitalization, although it may not be the primary cause of either. The prevalence of diabetes is reported to be higher for African Americans and Hispanics than for Whites. Interestingly, these increases have appeared only in the last 30 years; military intake data from World Wars I and II show diabetes rates among African American inductees were only one-third and two-thirds (respectively) the rate for Whites.⁵ Because there are several known and proposed risk factors for diabetes, assessing the increased prevalence of these risks in the African American population, especially as compared to the early 20th century, may yield clues to increases in other, related chronic conditions among African Americans.

Finally, understanding how treatment, as well as the availability of and access to treatment, impacts the prevalence of chronic diseases is critical in planning to meet future health care needs. With the advent of drugs to control diabetes and

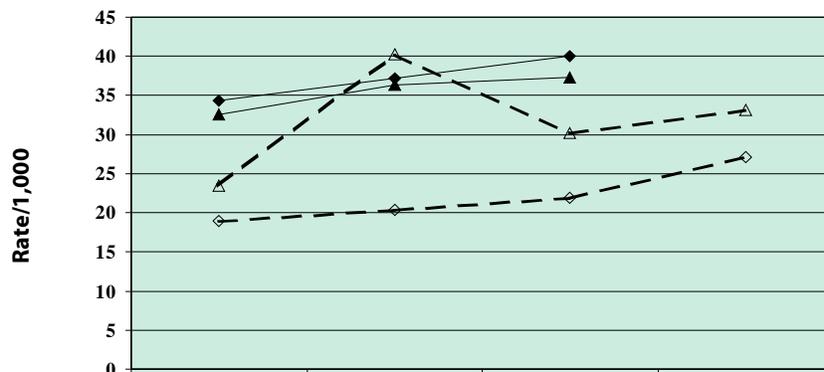
* Data not available for this year.

Morbidity and Chronic Disease

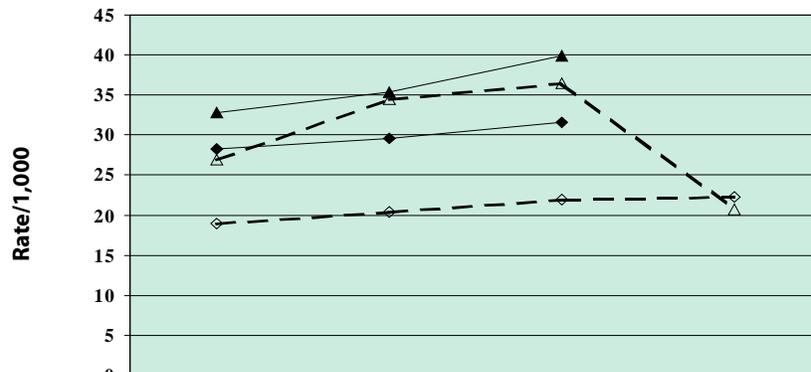
Cerebrovascular Disease, by Race, Females Age 65-74



Cerebrovascular Disease, by Race, Males Age 75 and Over



Cerebrovascular Disease, by Race, Females Age 75 and Over



decrease cholesterol (one of the components of the “fatty plaques”), and with the known and potentially positive effects of exercise and nutrition on each, efforts should be made to gather race- and age-specific information from providers that work with these populations.

Other Heart Diseases

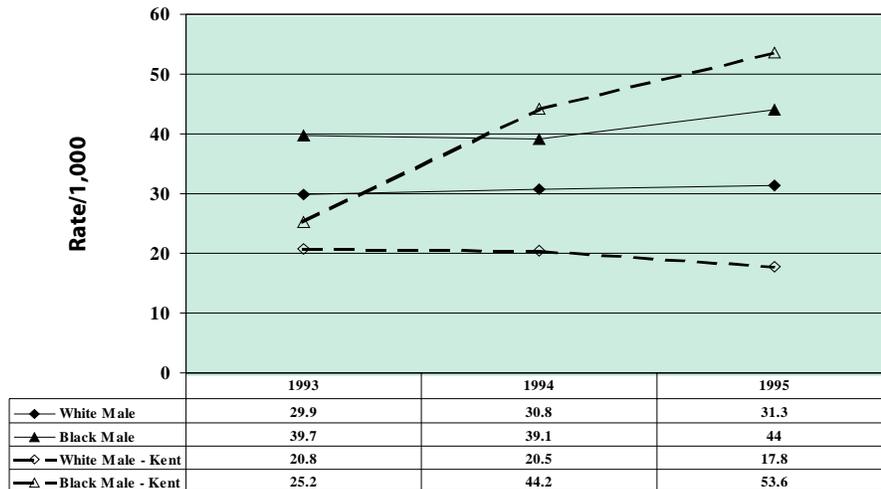
Hospitalization data for “other heart disease” includes discharges for heart disease other than ischemic heart disease: heart rhythm anomalies, hypertensive disorders, heart valve repairs/replacement, and congestive heart failure, among others. However, because there is significant interaction, and perhaps synergy, among the major diagnosis (i.e. conditions) at time of discharge, hospitalization data does not provide a complete picture of heart disease incidence overall. For example, hypertension (high blood pressure) is a major predisposing factor for Congestive Heart Failure (the leading diagnosis in “other heart diseases”). While hospitalizations for hypertensive disorders may be low, the aftereffects of the disease — congestive heart failure — remain high.

There are multiple causes for hypertension, from excess sodium intake and obesity to poor balance of kidney regulating mechanisms. Racial/ethnic differences in the cause of hypertension require differences in treatment regimens. Manton

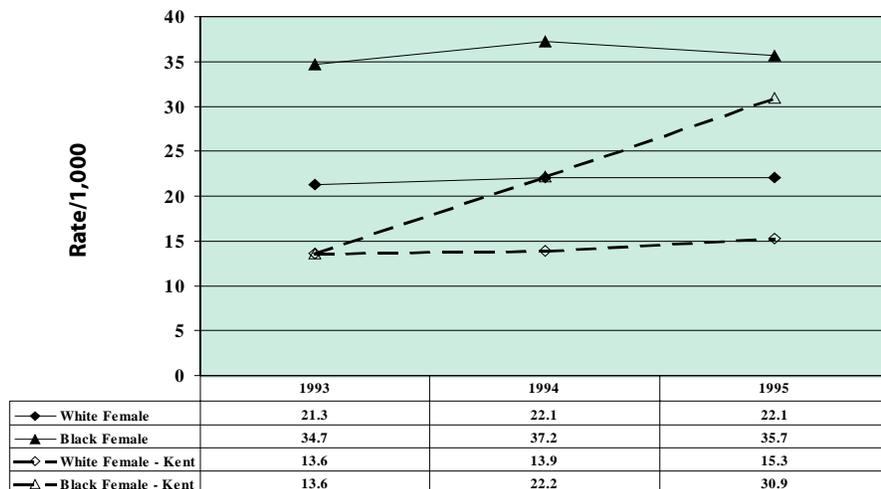
* Data not available for this year.

Morbidity and Chronic Disease

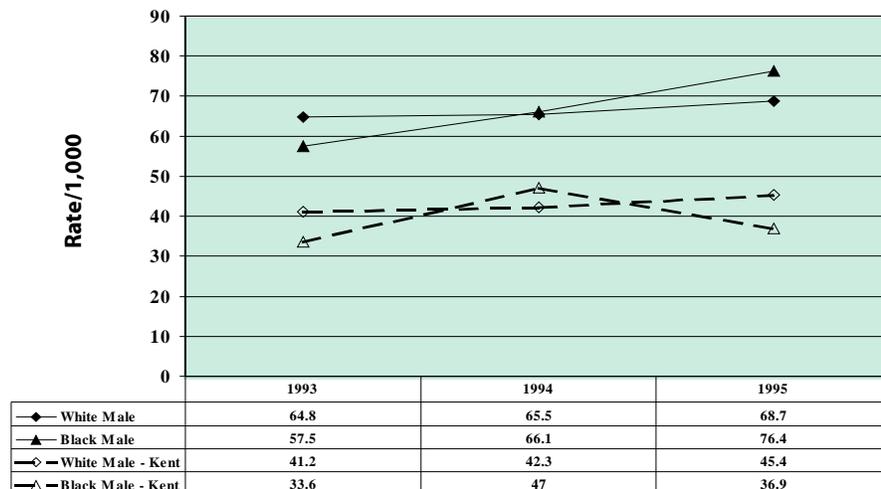
Other Heart Disease, by Race, Males Age 65 to 74



Other Heart Disease, by Race, Females Age 65 to 74



Other Heart Disease, by Race, Males Age 75 and Over



and Stallard (1997) in a review of racial/ethnic differences in the health of older Americans state:

“Antihypertensive drugs have different efficacy in different age and racial groups, which suggests different, age evolving race-specific (and ethnic-specific) etiologies for hypertension. Calcium channel blockers were most effective in young (under 60 years) and old (over 60 years) black males. Catopril worked best in young white males. Beta blockers worked best for older white males.”

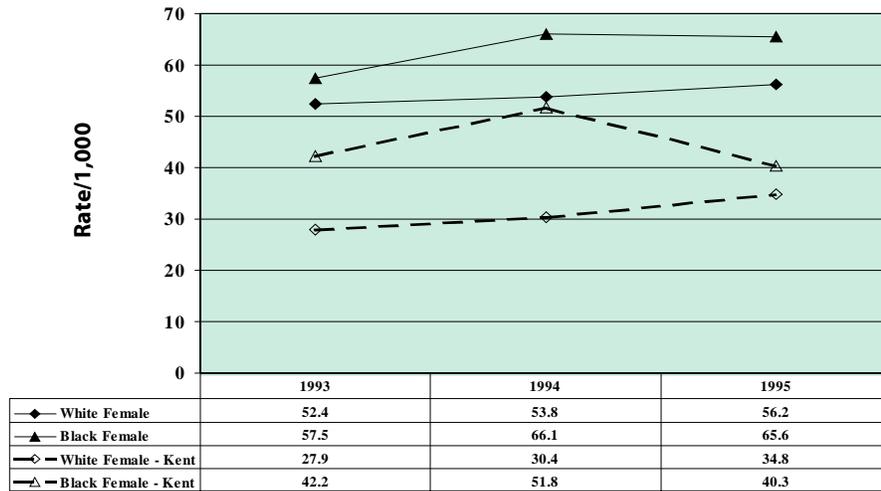
Additional local information is needed to determine the extent to which older African Americans and other minority groups have access to health care and treatment for chronic disease. In addition, because prescription medications are integral to the treatment of most chronic diseases, assuring that all older Americans have prescription drug coverage, either through Medicare or supplemental coverage, is critical to both controlling preventable hospitalizations and enhancing the quality and quantity of life in this population.

Cancer

Hospitalizations due to cancer reflect treatment and end-of-life care for 35 related diseases (i.e. types of cancer). Hospitalization rates for cancers other than lung cancer are presented here. However, because of few occurrences for specific cancers in the African American population, discharges for all other

Morbidity and Chronic Disease

Other Heart Disease, by Race, Females Age 75 and Over

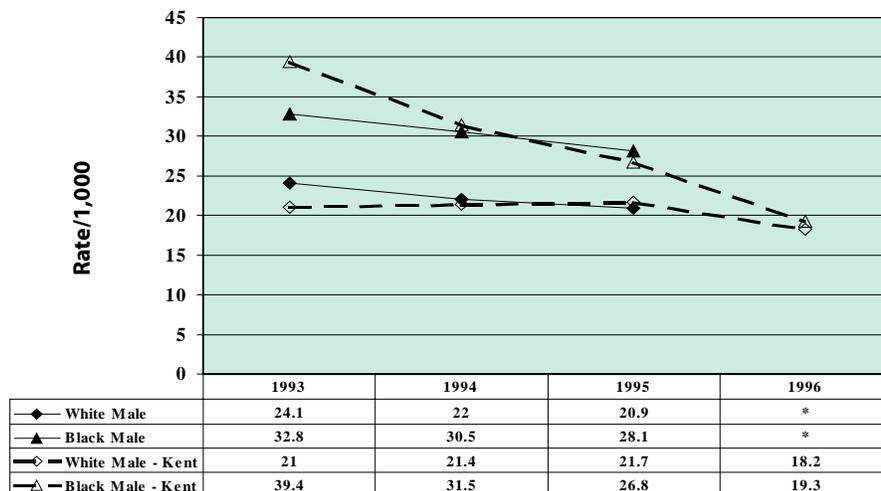


cancers (other than lung cancer) were summed for an overall rate.

In general, hospitalizations for cancer follow mortality trends for Kent County residents: higher rates in the African American population than the White population, with Kent County rates slightly lower than Michigan rates.

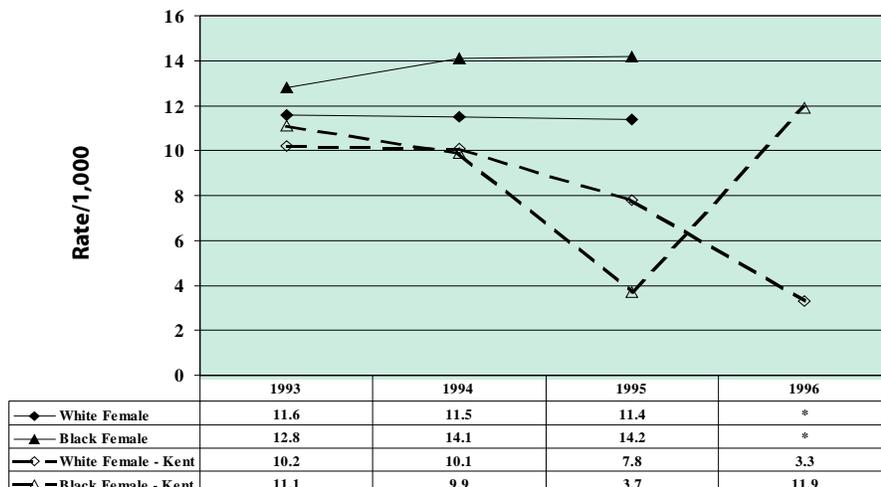
Manton and Stallard (1997) discuss racial/ethnic differences in occurrence and treatment of prostate, breast and cervical cancer, and multiple myeloma. Based on national mortality data, they report higher rates of cancer deaths for African Americans than for Whites, Hispanics, and Asian Americans. Hispanic cancer death rates are lower than African Americans, but higher than Whites. Asian Americans had lower rates of death for most types of cancer than all other groups.

Other Cancers, by Race, Males Age 65-74



These differences are most likely related to access to care and treatment, as well as to cultural differences that affect diet and other lifestyle behaviors. Manton and Stallard (1997) also cite research that suggests there are biological differences in tumor type and aggressiveness for several types of cancers including cancers of the prostate, breast, and cervix. In general, African Americans experience more aggressive forms of these cancers, and at an earlier age. African Americans are also more

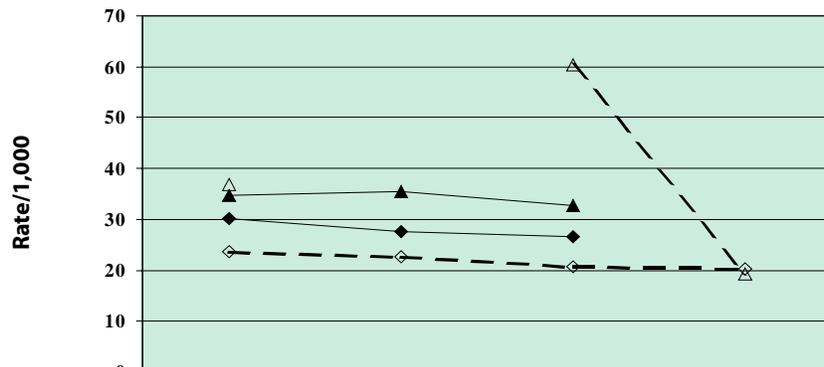
Other Cancers, by Race, Females Age 65-74



* Data not available for this year.

Morbidity and Chronic Disease

Other Cancers, by Race, Males Age 75 and Over

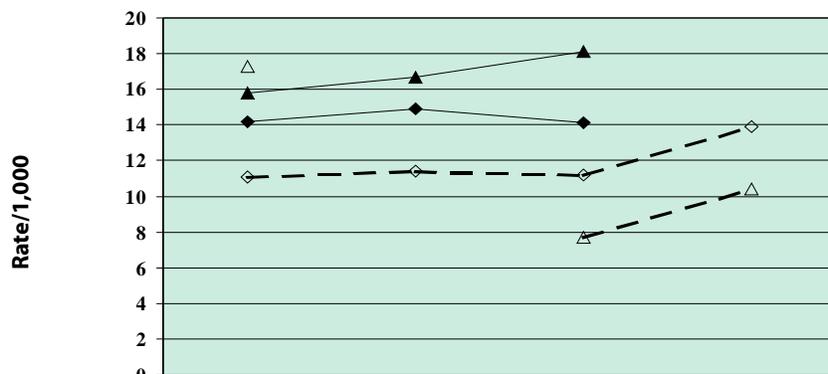


	1993	1994	1995	1996
White Male	30.2	27.7	26.7	*
Black Male	34.8	35.5	32.8	*
White Male - Kent	23.7	22.6	20.8	20.4
Black Male - Kent	36.9	**	60.4	19.4

likely to seek treatment at a later stage of the cancer development – reducing treatment options, outcomes, and survivability — than are Whites, Hispanics, or Asian Americans. Because early cancer treatment increases survival rates, African Americans experience lower rates of survival regardless of the aggressiveness of disease.

* Data not available for this year.
 ** Number of cases is insufficient to calculate accurate rate.

Other Cancers, by Race, Females Age 75 and Over



	1993	1994	1995	1996
White Female	14.2	14.9	14.1	*
Black Female	15.8	16.7	18.1	*
White Female - Kent	11.1	11.4	11.2	13.9
Black Female - Kent	17.3	**	7.7	10.4

Conclusion

Resources to Care for An Aging Population

As the baby boom generation reaches retirement age, there will be profound changes in medical expenditures for the senior population. In 1995, there was a real per capita personal health-care expenditure of \$9,231 for adults 65 and over. Based on current yearly increases, that cost is expected to reach \$24,391 by the year 2020³. Much of the increase in expenditures can be attributed to the costs of medical technology, as well as the need for and development of new and better drugs to control the underlying causes of disease. However, most evidence indicates that there is also a greater percentage of the senior population utilizing health care services than in the 1980s.³

Controlling costs of health care will require better primary prevention efforts, and for seniors, more attention to secondary and tertiary care. In a recent qualitative assessment of the needs of Kent County seniors, both transportation and financial support for prescription drugs were identified as needs of the local older adult population (Of the 27 focus groups polled, 70% of senior participants indicated a need for better public transportation, and 31% were concerned about the costs of prescription drugs).⁶

Transportation is a basic need that can affect the ability to access health care, and tends to affect the most vulnerable of the population — those without resources for private transportation. The costs of prescription drugs tend to affect those on a fixed retirement income without supplemental insurance (although Medicare does not cover prescription drugs, Medicaid will cover the costs of prescriptions for seniors who qualify).

Seniors also expressed a need for ancillary services that could improve the quality of their lives: meals (30%); help with chores around the home (55%); to be checked on regularly (36%); more stimulating activities (30%); more information on services (31%); and home health care (16%).⁶

Multiple factors influence the health of a population, and assuring that all have access to (advances in) health care is a priority for public health in the new millennium. But such assurances will require improvements in the way we currently collect and analyze information about the use of primary, secondary, and tertiary health care services. The ability to document changes in the health status of all minority populations through better data on race/ethnicity and income status is critical to truly understanding the needs of our aging population. Developing the means to collect and report on this data locally must be a priority.

In a 1990 review of multiple studies on inequities in health care among African Americans and Whites, the Council on Ethical and Judicial Affairs, American Medical Association, reported “persistent, and sometimes substantial, differences in the quality of health among Americans.”⁷ The studies reviewed — follow-up to patients discharged for conditions associated with the leading causes of death — showed that in general African Americans and persons of lower socioeconomic status were less likely to receive more sensitive diagnostic tests for the presence of disease, or more advanced intervention when a disease was present (e.g., coronary bypass surgery or kidney transplants).

One of the goals of Healthy People 2010, national health goals from the U.S. Department of Health and Human Services, is to end racial disparities in health status by the year 2010. Documenting care and treatment for minority and low-income persons is a priority concern for Healthy Kent 2010, and finding ways to improve the level of information used in health planning will provide a significant challenge to Healthy Kent partners. At the same time, future health planning efforts must not only be concerned with assuring equal access to care and treatment, but in planning for the needs of the largest generation of older adults in U.S. history.

Notes

References

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Notes

Publication Information

[Assessing the Health of Older Adults in Kent County: Report to the Community, 2000](#)

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Grand Rapids, MI

Citations may cite the title of this report, or the Kent County Health Department.

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